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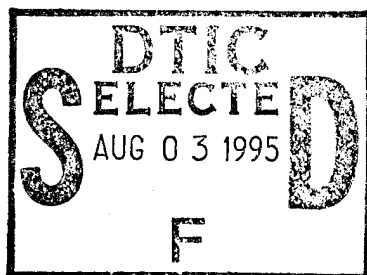


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NAVAL POSTGRADUATE SCHOOL MONTEREY, CALIFORNIA



THESIS

**MILITARY HEALTH CARE SYSTEM:
COMPARING ORTHOPEDIC COSTS BETWEEN
A MILITARY
TREATMENT FACILITY AND CHAMPUS**

by

Geralyn A. Haradon

December, 1994

Principal Advisor:

William R. Gates

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**MILITARY HEALTH CARE SYSTEM: COMPARING ORTHOPEDIC COSTS
BETWEEN A MILITARY TREATMENT FACILITY AND CHAMPUS**

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ABSTRACT

For more than three decades, two systems have provided health care for military beneficiaries: (1) the direct care system, whereby beneficiaries obtain health care services from military treatment facilities (MTFs), and (2) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a health program in which beneficiaries receive care from civilian providers. The rising cost to the Department of Defense (DoD) of supplying quality medical care in a constrained financial environment, has prompted many suggestions for reforming the military health care system. The objective of this research is to compare costs between a military treatment facility and CHAMPUS and to determine whether a given MTF can provide inpatient care to its beneficiaries at lower cost than through CHAMPUS. By comparing MTF and CHAMPUS costs, a given MTF can identify those specialty areas in which to reduce costs either by increasing workload (CHAMPUS recapture) or increasing referrals to health care providers outside the MTF.

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I. INTRODUCTION

A. BACKGROUND

For more than three decades, two systems have provided health care for U. S. military beneficiaries: (1) the direct care system, whereby beneficiaries obtain health care services from military treatment facilities (MTFs), and (2) the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), a health program in which beneficiaries receive care from civilian facilities. [Ref. 17:p. v]

The Department of Defense (DoD) now spends \$15 to \$17 billion a year on medical services. About \$5 billion of this spending covers the military treatment facilities (MTFs). DoD's desire to minimize the cost of providing medical care while maintaining quality and timeliness of service, has prompted many suggestions for reforming the military health care system.

CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services, a Department of Defense program for reimbursing individuals and health care providers for services provided by the civilian sector to eligible beneficiaries and retirees. It pays most of the costs for treatment in civilian medical treatment facilities when space and resource constraints at military hospitals and clinics make direct care inaccessible. The family members of active-duty personnel, retirees and their dependents under 65, some former spouses of service members, and certain survivors are eligible for CHAMPUS. Families of reserve and National Guard members called to active duty are also eligible.

B. OBJECTIVES OF THE RESEARCH

For the past decade, the CHAMPUS budget has grown substantially for several reasons. First, the Department of Defense has significantly expanded in size, increasing the number of military personnel whose medical care is the

military's responsibility. Additionally, there is a greater percentage of service personnel entering the military with family members, compared to previous years. These additional family members, especially children, have a tremendous need for medical services. Consequently, the need for health care far exceeds the capacity of overburdened military providers. Second, there is a rise in total national health care expenditures. [Ref. 13:p. I-3,5] These costs have grown excessively when compared to inflation.

In Fiscal Year (FY) 1993, approximately 8.7 million people were eligible for DoD health care benefits, including 1.9 million active duty personnel, 2.7 million family members, and 4.1 million retired military personnel and their dependents and survivors. From Operations & Maintenance (O&M) funds, CHAMPUS expenditures in FY-93 approached \$3.5 billion, nearly as much as was spent on non-active duty beneficiaries in the "direct care" military treatment facility (MTF) system (\$3.9 billion). Over the last few years, a variety of modifications to the MTF and CHAMPUS systems have been implemented to reduce these costs. These include the CHAMPUS Reform Initiative (CRI) demonstrations, Base Realignment and Closure (BRAC) site managed care initiatives, Tidewater Virginia demonstration project (coordinated care), PRIMUS/NAVCARE Clinics, and most recently, the Managed Care Support Contract for California/Hawaii and Oregon/Washington.

The objective of this research is to compare direct care (MTF) and Standard CHAMPUS costs to determine whether a given MTF can provide inpatient care to its beneficiaries for a particular specialty service at a lower cost than through CHAMPUS. The analysis provides a method of calculating MTF specialty cost per admission that can be compared to the equivalent specialty cost reported by

CHAMPUS.

C. RESEARCH QUESTION

The primary question of the thesis is: Is it more cost effective to treat non active duty beneficiaries for inpatient orthopedic care in the direct care system (MTF) or be refer them to the indirect care system?

D. SCOPE

This thesis will concentrate on Naval Hospital, Oak Harbor (an MTF) and its localized catchment area in the vicinity of Oak Harbor, Washington.¹ The analysis and cost comparison will be limited to Orthopedics because this specialty can be very resource intensive. The analysis will focus on inpatient orthopedic costs covered by Standard CHAMPUS funds in 1993. This is the most recent year for which complete and relevant data exists. For consistency, 1993 orthopedic costs will also be used for the Naval Hospital, Oak Harbor.

This study analyzes data generated prior to FY-95. As of 01 October 1994, there was a policy change regarding MTF financing. MTFs are now financed on a capitated rate, derived by the demographics of the catchment area. Each MTF is allocated a pre-determined capitated rate per beneficiary. This will change the MTF commanders' incentives for cost control in the MTF. In the past, MTF commanding officers had no incentive to reduce CHAMPUS costs because they were not responsible for CHAMPUS expenditures. Now each MTF commanding officer receives a CHAMPUS dollar target towards which to manage. If actual costs exceed this target, the MTF's O,M & N funds ultimately can be reduced by the amount the CHAMPUS target is exceeded. MTF commanding

¹This catchment area includes all beneficiaries residing near Naval Hospital, Oak Harbor (within a 40 mile radius) who use CHAMPUS as their primary insurer for inpatient care.

officers are responsible for providing all medical care for their beneficiary population within this capitated budget, irregardless of the actual level of service. Previously, MTFs were funded based on workload. The philosophy was, the more workload generated the more dollars received.

E. METHODOLOGY

Normally, participating health care providers are paid by CHAMPUS at a Champus Maximum Allowable Charge (CMAC). This is a Current Procedural Terminology (CPT) code specific reimbursement methodology developed by the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). It is used to reimburse all fee-for-service professional services for the CHAMPUS beneficiary population. OCHAMPUS uses this pricing methodology to compensate providers for the technical component of outpatient services, such as laboratory and radiology.

This research uses data on cost per admission from the CHAMPUS Inpatient Care Summary report. The CHAMPUS Inpatient Care Summary report provides the combined cost of hospital and professional services for 27 hospital specialties. The analysis concentrates on the CHAMPUS cost for orthopedic cases.

The MTF average cost per admission for orthopedic patients is developed using data from the Medical Expense and Performance Reporting System (MEPRS). MEPRS tracks total costs (hospitalization and physician costs) and occupied bed days (OBDs) by functional work centers. MEPRS data on cost per OBD by work center can be used to calculate average cost per admission based on the number of days the typical patient remains in each MEPRS work center. The cost of each admission is calculated by summing the product of the number of days spent in each work center and the corresponding cost per OBD.

II. THE MILITARY HEALTH SERVICES SYSTEM

A. OVERVIEW OF THE MILITARY HEALTH SERVICES SYSTEM

Health care for military beneficiaries is provided through a dual system: The Navy, Army, and Air Force operate approximately 137 hospitals and numerous clinics in the U. S. and overseas. When military treatment facilities cannot provide care for all eligible beneficiaries, their health care needs may be augmented by CHAMPUS, a health insurance plan that reimburses for health care services provided by civilian practitioners to military dependents and beneficiaries under age 65. [Ref. 17:p. 1]

The Military Health Services System (MHSS) is undergoing major changes, driven by the momentum of national health care reform, affecting both the health care options available to our beneficiaries and some of the functions and organizational structures of the Military Services' medical departments. The Department of Defense (DoD) health care reform program, known as TRICARE, is designed to promote the effective execution of the military health care mission, ensure access to a quality health care benefit, control health care costs, and respond to changing military and national health care priorities.

As with the rest of the country, the Department of Defense is experiencing a significant evolution in its health services system. Driving much of the change for DoD is the rapid downsizing of the Army, Navy and Air Force's active duty and reserve forces. Ships, aircraft squadrons, divisions and bases are being mothballed and eliminated at a fast pace, while the military personnel strength shrinks in response to the smaller force. Active duty soldiers, sailors, and airmen numbered 2.2 million at the peak of Operation Desert Storm. They are now at 1.7 million, on their way to 1.4, or possibly 1.2 million by 1996. At the

same time, health care costs move upward.

A number of factors contribute to cost escalation. One is the nature of the military medical mission. The primary focus of the Defense Department is deterrence of aggression through combat readiness. This applies equally to the medical forces. They must be constantly prepared for casualties, perhaps massive in number and severity. That requires a significant investment in medical resources and personnel deployed with the active forces around the world, and at medical treatment facilities. Maintaining large medical forces is costly in both dollars and manpower.

There is another cost associated with medical readiness. Medical professionals must continue to hone their skills, just as pilots, soldiers and sailors. Skill readiness has been historically achieved through providing space available services to dependents of active duty military, and to retirees and their family members. The diversity of the medical care needs presented by these groups has offered sufficient volume and intensity to keep health professionals well practiced.

However, space available status has led non-active duty personnel and family members to expect entitlement for health care services at the MTF despite the lack of legal foundation. The CHAMPUS indemnity program was established in the 1960's to provide care for beneficiaries in civilian facilities when military hospitals are over-burdened or unable to meet the specific medical needs of beneficiaries. During conflicts, such as Operation Desert Storm, Congress has acted to ensure the continued availability of care for non-active duty beneficiaries. During Desert Storm, a number of Reserve physicians and other providers were recalled specifically to maintain the level of service for beneficiaries at military medical treatment facilities.

B. THE DIRECT HEALTH CARE SYSTEM OF MHSS

To understand military medicine, it is important to note that active-duty individuals have first priority in the MTFs. Preserving the fighting force is military medicine's fundamental mission. Members on active duty receive free medical care, including hospitalization, medicines, immunizations, regular physical examinations and dental care. Also, all military hospitals can treat any member of the seven uniformed services: Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration. Any active-duty member that can not get to a military facility for emergency care may be treated at civilian hospitals; the military will pay the bill through the Office of Medical Affairs.

Other beneficiaries are treated only if medical staff and resources are available after treating those in uniform. Family members of active-duty members, including family members of reservists on active duty, have second priority. Retirees and their family members have lowest priority. As with any hospital, however, the military's priority list is put aside during emergencies. No one in need of emergency care is turned away.

Access to the Department of Defense's medical resources for non active duty beneficiaries is controlled by Defense Eligibility and Enrollment Reporting System (DEERS). This is the military's computerized data base of individuals eligible for military medical benefits; active-duty personnel are automatically enrolled while qualifying family members must be enrolled.

Families of active-duty members and activated reserves are eligible for treatment at military treatment facilities as long as they are enrolled in DEERS. Those qualifying as family members include:

1. The spouse and unmarried children (under 21 years of age) of active-duty members;
2. Unmarried children over 21 who receive more than 50 percent of their financial support from a military parent (limited to children with physical or mental handicap);
3. Unmarried children not yet 23 years of age who are full time students at accredited colleges and who must depend on a military parent;
4. Parents or parents-in-law who live in a residence provided or maintained by their active-duty son or daughter (in-law) and who receive more than half their financial support from the service member; and
5. Unremarried widows and widowers of active duty members or retirees. [Ref. 12:p. 15-20]

Family members can receive several kinds of medical services at military treatment facilities including: treatment of medical and surgical conditions, physical examinations, prescription and non-prescription drugs, emergency dental care, and ambulance service when medically necessary.

As with all health care programs, care is generally divided into outpatient and inpatient. Inpatient treatment occurs when an individual is admitted to a hospital with the reasonable expectation that such individual will stay at least 24 hours. Outpatient treatment occurs in a physician's office or clinic, or during a house call.

As with active-duty family members, retirees and their families are not charged for outpatient treatment at military treatment facilities. Retired members are not charged for inpatient care while retired officers and warrant officers pay a nominal fee of \$4.65 a day for meals (for FY-1994). Spouses and dependents of retirees' are billed \$9.30 a day (for FY-1994). See Figure 1.

Beneficiary	Out Patient	In Patient
Active Duty	X \$0.00	X \$4.65/day
Active Duty Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day
Retired (Enlisted)	SPACE A \$0.00	SPACE A \$0.00
Retiree (Enlisted) Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day
Retired (Officer)	SPACE A \$0.00	SPACE A \$4.65/day
Retired (Officer) Beneficiary	SPACE A \$0.00	SPACE A \$9.30/day

**Figure 1. Military Treatment Facility
Health Care Services Eligibility and Cost**

Retirees are also eligible for medical care from the Department of Veterans Affairs (VA). Priority is determined as follows:

First priority (Category A) includes all veterans with service connected disabilities; veterans claiming exposure to Agent Orange while serving in Vietnam; and those veterans claiming exposure to ionizing radiation through occupation in Hiroshima or Nagasaki, Japan following detonation of the nuclear device or through testing of those or other such devices. Veterans, such as former prisoners of war are automatically included in Category A. Also included are veterans with an annual income of \$19,912 or less if they have no dependents, or \$23,896 with one dependent, plus \$1330 for each additional dependent. This group is considered mandatory.

Discretionary care is provided if space and resources are available, covers veterans with disabilities that are not service-connected and whose annual income is less than \$19,912 if they have no family members, or less than \$23,896 with one dependent, plus \$1,330 for each additional dependent. Veterans in this category must pay a deductible equal to what is paid under Medicare, \$696 in 1994.

They are also charged \$10 a day for inpatient care, \$5 a day for nursing home care, and \$36 for each outpatient visit. [Ref. 14: interview]

In an effort to alleviate overcrowding at hospitals, the services have opened a number of medical clinics. These clinics are manned by civilian health care providers and offer primary care to both active-duty personnel, retirees and family members. The Navy calls its clinics NavCare; the Army and Air Force call them PRIMUS. Eligible members and their families may enter any of these clinics, and receive service free of charge. Services include treatment for minor illnesses, routine physical exams, diagnostic services, X-rays, prescriptions and laboratory tests.

Members on active-duty are also entitled to receive dental care in military dental clinics. In order of priority, active-duty family members, including family members of recalled reservists, retirees, and retirees' family members may also receive emergency dental care at these facilities on a space available basis. Such care is free, except that family members must pay for prosthetic devices. These charges reflect the cost of the materials and not manpower costs.

The Department of Defense also offers active-duty family members in the U. S. and its territories dental treatment by participating civilian dentists through an insurance plan. The plan provides free diagnostic care, oral exams, and preventive care such as fluoride treatments. The plan pays 80 percent of other charges and the patient pays 20 percent. [Ref. 9:pp. 1-5]

C. THE INDIRECT MHSS HEALTH CARE SYSTEM

CHAMPUS was created by Congress when eligible beneficiaries were unable to access military treatment facilities. Its budget has been rising steadily for several years. In 1993, its total DoD budget was \$3,608,800 up from

\$3,372,600 in 1992. [Ref. 15:p. 1] In 1993, the total number of claims was 18,673,383 up from 17,910,083 in 1992. [Ref. 15:p. 1]

The Champus program offers a "triple option" system which provides standard, prime, and extra options. The standard option is basically an indemnity insurance that pays 80 percent of allowed charges while the beneficiary pays 20 percent after deductibles are met. The prime option is like a Health Maintenance Organization (HMO) where members enroll and pay minimal co-payments when treatment is sought from a specified list of providers. The extra option is like a Preferred Provider Organization (PPO) which is similar to the HMO but allows the beneficiary more choice in provider networks.

The following groups are eligible for CHAMPUS benefits: family members of active duty members; surviving spouses and unmarried children of service members and reservists who died while on active duty; spouses and unmarried children of reservists who are called to active duty for more than 30 days, and the survivors of reservists who died on active duty; members of the reserves between the age of 60 and 65 who are qualified to receive retired pay; surviving spouses and children of deceased retirees (spouses who remarry are ineligible unless married to eligible member); and children of active duty members or retirees up to age 21 if not married, and to 23 years of age if not married and enrolled full time in an accredited college or university.

As a rule, CHAMPUS coverage automatically ends when a participant turns 65. Most military retirees and their family members lose CHAMPUS eligibility when they become eligible for Social Security's Medicare program. However, retirees and their family members maintain their privilege for treatment in military treatment facilities on a space available basis.

D. THE EVOLUTION OF MANAGED CARE

As America entered the twentieth century, society transformed from a predominantly agricultural economy to a manufacturing economy. The manufacturing economy gave rise to big business over small, family-owned operations causing a shift in focus from individual operation to that of institutional domination. [Ref. 16:p. 5]

During the last fifty years, society in every developed country has become a society of institution. Every major task whether performance or health care, education or protection of the environment, the pursuit of new knowledge or defense, is today being entrusted to big organizations, designed for perpetuity and managed by their own management. [Ref. 3:p. 6]

Simultaneously, in the medical arena, a historical transition from generalist to specialist occurred. This transition set the seed for corporate management of medical care. Specialized medicine quickly began to unfold during World War II. With the surge of new technology, physicians started to specialize in certain areas of medicine. There was an increased emphasis on specialized medical training and facilities. Physicians released from military service were entering residency programs in various specialties. At the end of World War II, practicing specialists started to flood the market as 100,000 medical personnel were released from active duty during the post war downsizing. By 1966, almost 70% of all practicing physicians were specialists while 30% were generalists.

Specialists began to practice in groups instead of working on their own. The costs of providing medical care, advances in technology, scientific evolution, and other economic forces were the main catalyst for this shift. Physicians would purchase expensive equipment as a group rather than practice on their own and bear all the expense.

Managed care has evolved over the past 50 years with Kaiser Permanente being the pioneer in this method of delivery system. The Kaiser Permanente Medical Care Program originated in 1942. It is the largest most widely distributed and best known health maintenance organization (HMO) in this country. [Ref. 2:p. 4] An HMO is a delivery system established to provide high quality health care medical services at a competitive price. Competition is the key variable. In order to remain competitive and attract new members, HMO's must continue to reduce cost and encourage "wellness" for its members. Keeping patients healthy allows the HMO to contain cost and provide appropriate medical care. After Kaiser Permanente proved successful at providing care through this type of delivery system, other group practices evolved into popular marketable entities that mirror the Kaiser system.

Preferred Provider Organizations (PPO) evolved as another managed care option. PPOs are slightly different than an HMO. A PPO is "a contractual arrangement between professional and/or institutional health care providers and employers, insurance carriers or third party administrators to provide health care services to a defined population at established fees." [Ref. 2:p. 5] In other words, a PPO is a loosely integrated network of health care providers. All members have agreed to provide services for a predetermined maximum price. Patients are free to choose between all member health care providers. Thus, PPO's allow the patient more choice than an HMOs: They represent a competitive form of bureaucratic organization in medical care. [Ref. 2:p. 27]

By mid 1979, there were 217 HMO's operating across the nation with a total enrollment of 7.9 million people. This figure had doubled in size since 1970. Clearly, a primary reason that HMO's have been successful is that physicians

have been able to accept some financial risk - the financial risk associated with providing medical care and services to a group of subscribers for a predetermined total cost. Both profits and losses are shared by all the physicians.

The Department of Defense has also begun to pursue innovative approaches to reinvent their health care delivery system. There were various projects tested throughout the United States such as CHAMPUS Reform Initiative (CRI) in California and Hawaii, CAMS in Charleston, South Carolina, and TRICARE Demonstration Project in Virginia. Reinventing the delivery of health care is a major undertaking for any organization, especially the military. The TRICARE project has been adopted by the three military services. It has involved developing 12 geographical regions, each with a designated Lead Agent to coordinate all medical care for that specific region.

E. TRICARE REGIONAL MANAGED CARE SYSTEM

In 1993, DOD has added several new components to the MHSS to begin its transition to a managed care concept of operation:

1. DoD is transitioning to a "capitation-based" method for allocating health care funds to the military departments. Capitation budgeting is a recognized strategy for health care cost containment. Under this concept, each MTF commander is responsible for providing health care services to a defined population for an average fixed amount per beneficiary.
2. DoD developed the "Triple Option" managed care program structure for CHAMPUS eligible beneficiaries.
3. DoD established 12 Health Service Regions (HSRs) within the U. S., each lead by a medical center commander designated as a Lead Agent. (see Figure 2).

4. DoD implemented a fixed-price-at-risk TRICARE Support Contract.² The support contractor established a network of civilian providers to augment MTF care within each area. The contractor provides fiscal and administrative support to Lead Agents for care purchased through these networks. These fixed-price -at-risk contracts will be procured centrally by OCHAMPUS, with extensive participation by the Lead Agent and Services' staffs. The contractor is expected to assist Lead Agents and MTFs to improve access to quality health care while controlling health care cost.

Capitation Budgeting Concept

A capitation-based resource allocation system is increasingly advocated to consolidate resources, develop services, focus responsibility, and manage care appropriately. Basically, capitation budgeting can be defined as a prospective reimbursement process where the health care provider is paid a fixed price per person to provide a defined range of services over a specified time period. [Ref. 12:p. 6] Under this definition, capitation has three crucial elements: (1) care is prepaid with a predetermined, agreed-upon price, and price does not vary according to the value or intensity of services; (2) the payment is tied to a specific population of capitated patients, typically involving some type of an enrollment system; and (3) the provider bears full financial risk if expenditures exceed payments. The provider keeps part of the savings, if not all of the medical costs are within the capitated payment. Similarly, the provider is liable for any costs that exceed the capitated budget. Combined, these

²A fixed-price-at-risk contract protects the contractor from financial risk as its workload is increased or decreased by the MTF.

elements give the provider a strong incentive to manage care wisely. [Ref. 12:p. 7]

Capitation budgeting fundamentally governs the users' payment to the organization providing health care. [Ref. 12:p. 8] It is not required that doctors or other professional personnel be paid on a per capita basis under capitation budgeting. Providers could be paid by the program in a wide variety of ways, including salary and fee-for-service. Those who finance care are more concerned with controlling aggregate costs than with the particular mode of remuneration among providers. [Ref. 12:p 8]

The "Triple Option" TRICARE Plan

The foundation of the TRICARE Program is a "triple option" of health care delivery for CHAMPUS eligible beneficiaries. Beneficiaries may choose from the following options:

TRICARE Standard: Individuals in this program enjoy unrestricted provider choice and pay no enrollment fees, but pay annual deductibles, co-payments and cost shares. This program is the basic CHAMPUS standard indemnity fee-for-service plan.

TRICARE Prime: Individuals in this program enroll in an HMO like plan and obtain their care from a network of civilian and military providers/hospitals. Enrollees pay an annual enrollment fee but face lower CHAMPUS cost shares and co-payments for point-of-service charges. Enrollees have access to enhanced preventive care services under this plan. They also have a Primary Care Manager (PMC). This doctor is responsible for coordinating required patient referrals for care within the MTF or civilian provider network. The point-of-service option under TRICARE Prime, allows enrollees to "go outside the provider network" for care. However, they are required to pay significant cost shares and deductibles which could exceed Standard CHAMPUS costs.

Finally, participants are relieved of claim filing responsibilities.

TRICARE Extra: Individuals don't have to enroll in this program, but agree to obtain care from their choice of providers within the PRIME network. Beneficiaries don't file claims and pay lower cost shares than required for non-network providers under the Standard CHAMPUS option.

The Lead Agent Concept

As previously stated, DoD established 12 Health Service Regions (HSR) within the United States, each with a designated Lead Agent MTF/Commander. Lead Agents work cooperatively with all the services' regional MTF commanders and their staffs to develop, implement, and manage the regional health plan for their MHSS beneficiaries. This includes developing an integrated health care network within their HSR. Lead Agents are responsible for:

1. developing an annual regional health service plan
2. developing clinical support contingency plans
3. developing regional TRICARE Support Contract requirements
4. developing procedures for coordinating health care delivery between military and civilian health care providers
5. monitoring CHAMPUS budget targets
6. coordinating utilization management and quality assurance activities
7. establishing priorities for routing beneficiaries to the direct care system
8. developing regional policy for coordinating patient referrals and issuing non-availability statements (NAS) in accordance with DOD policy
9. coordinating the development of an annual regional capitalization, maintenance, repair and renovation plan for all MTFs within the HSR in concert with

regional MTFs

10. conducting ongoing evaluations and coordinating corrective actions relative to resource utilization, clinical services, and access as appropriate.

MTF Commanding Officers retain their Service designated Chain of command irrespective of their Lead Agent's Service affiliation. The Lead Agent has no command and control over the individual MTFs within their region. The Lead Agent's report to their service specific headquarters and the Assistant Secretary of Defense for Health Affairs. Each Service will retain existing authority to make decisions regarding direct care (MTF) operating funds, facility maintenance, and personnel actions. For the Lead Agent concept of managing CHAMPUS resources to be successful requires each service within the region to work together openly and cooperatively.

TRICARE Managed Care Support Contracts

The transition from an exclusive fee-for-service (Standard CHAMPUS) program to the TRICARE Triple Option as described is now underway and will be completed within the next three years. These fixed-price at-risk contracts will be procured centrally by OCHAMPUS, with extensive participation of the Lead Agent and the Services' staffs, and will assist Lead Agents and MTFs in improving access to quality health care and controlling health care costs.

III. METHODOLOGY

A. SOURCES OF DATA

The data used for this research comes from two organizations. Naval Hospital Oak Harbor, Oak Harbor, Washington furnished the Medical Expense and Performance Reporting System (MEPRS) and occupied bed day (OBD) data on inpatient orthopedic care for fiscal year 1993.

The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in Aurora, Colorado provided the Health Care Summary Report. The Health Care Summary Report shows CHAMPUS utilization and cost data for the Oak Harbor catchment area.

B. OVERVIEW OF MEPRS

MEPRS contains cost and workload performance information for military treatment facilities. MEPRS recognizes six general functional areas within an MTF: inpatient, outpatient, dental, ancillary services, support services, and special programs. Support services are laundry service, food service, housekeeping, and other non medical functions. Ancillary services include clinical laboratory, pathology, radiology, pharmacy, and other related activities that contribute to the proper diagnosis and treatment of admitted patients. Special programs consist of graduate medical education, public health services, and decedent affairs. Within the general functional areas, MEPRS further identifies separate work centers of the MTF in which different services are performed. It tracks workload and expenses by these work centers.

Average expenses from ancillary and support work centers are reallocated or reassigned to the work centers and other final operating accounts. This allocation is based on the percentage of the ancillary and support workload performed for the work centers. For example, the

performance factor for Blood Bank is a weighted procedure (see Appendix A for sample of performance factors). If 20% of Blood Bank laboratory procedures (i.e tests performed to prepare units of blood for patients) are requested by the Orthopedics physicians, then 20% of the cost of operating the Blood Bank are allocated to Orthopedics care (work center).

Expense information is entered in the MEPRS as a Direct Expense Schedule (DES). The DES identifies all expenses directly associated with a given work center including the ancillary and support work centers. Information is provided by the departments and is then rolled up by the MEPRS system. Workload information is gathered from numerous sources, including the Automated Quality of Care Evaluation Support System (AQCESS) and the Tri-service Medical Information System (TRIMIS). AQCESS provides OBDs by work center and TRIMIS provides ancillary workloads.

Workload statistics are calculated in MEPRS through stepdown assignment statistics (SAS) data sets. Each SAS data set includes a numerical identifier that is related with a specific workload measure and a list of the MEPRS work centers and corresponding workload for that work center.

The Expense Allocation System (EAS) is the automated system that processes the actual cost allocations from the intermediate operating accounts to the final accounts. EAS charges direct expenses of the ancillary and support work centers to the inpatient, outpatient, dental, or special programs work centers benefiting from the expenses.

During the final purification or post-stepdown, expenses from cost pools are allocated to final operating accounts in EAS. Cost pools are established when costs are shared by two or more final operating accounts.

The Final Purification Report identifies the expense

distribution from cost pools to final accounts. This report shows the dollar amounts calculated and allocated during purification.

The Computation Summary reveals the breakdown of total work center expense by direct expense, support costs, ancillary costs, expense from cost pools, and a final purified amount.

C. MEPRS DATA FOR INPATIENT ORTHOPEDIC CARE

Data provided by Naval Hospital, Oak Harbor, Washington covered only the inpatient services and work centers involving Orthopedic costs.³ Five reports were used for analyzing Orthopedic cases. These reports are included as Appendices B, C, D, E, and F. Appendix B (Occupied Bed Day Data) accounts for all the occupied bed days for the inpatient work centers. Appendix C (Direct Expense Summary) shows the total salary of clinicians working in those particular work centers. Appendix D (Stepdown Schedule) enumerates all the ancillary and support costs allocated to the affected work centers. Appendix E (Final Purification Report) shows the costs allocated to different work centers from the ward cost pools. Appendix F (Computation Summary Report) integrates all the different costs allocated to the work centers.

Naval Hospital Oak Harbor provided their complete MEPRS data for FY-93 (01 October 1992 to 30 September 1993). However, the data needs to be analyzed carefully because of MEPRS's inherent limitations. For example, data is collected by functional work center instead of by individual patient. When admitted patients in a given specialty are treated in two or more work centers, cost per admission must be calculated from data on cost per OBD by work center and

³To date, there are 6 identified inpatient specialties within the Naval Hospital Oak Harbor (see Appendix J-Inpatient Specialties).

treatment provided by the specialty. Second, since MEPRS is an allocative system, a work center's share of support and ancillary costs is determined by its relative share of weighted workload. If weights do not capture all differences in resource consumption for ancillary and support costs, then the allocated cost could be different from the true cost. As a result of these limitations, estimating the cost per admission in a given specialty using patient treatment protocols cannot truly reflect actual cost.

D. OVERVIEW OF THE HEALTH CARE SUMMARY REPORT

The Health Care Summary Report (HCSR) is produced by OCHAMPUS on a quarterly basis to show CHAMPUS utilization and health care expenditures at the individual MTF catchment area and regional level. The Health Care Summary Report provides CHAMPUS data broken out by hospital specialty.

The Health Care Summary Report provides data on various CHAMPUS statistics. The major breakouts of information on this report are:

Hospital Specialty - (Adverse Reactions, Allergy, Cardiology etc.)

Category of Beneficiary - (Family Members of Active Duty, Retirees, and Family Members of Retired/Deceased.)

Type of Care - (Hospital, Inpatient Professional, Outpatient Professional, and Outpatient Cost Shared as Inpatient)

E. CALCULATING COSTS FOR INPATIENT ORTHOPEDIC TREATMENT

For Orthopedic cases, the total expense is \$650,000 for Naval Hospital, Oak Harbor in fiscal year 1993⁴. This

⁴For the fiscal year 1993, 99.50% of patients admitted at Naval Hospital Oak Harbor for Orthopedics care were seen and treated at that work center. The remaining .50% were treated by two or more work centers. They were not included in the analysis because the effect is considered negligible in the final cost per admission.

includes all clinician and military salaries. Furthermore, 199 orthopedic patients were admitted in fiscal year 1993. Dividing \$650,000 by 199 yields a \$3266 average cost per orthopedic patients.⁵ The OBDs totaled 475. Dividing 475 OBDs by 199 patients yields a 2.387 average length of stay (ALOS) or occupied bed days (OBD). Furthermore, dividing the total expense of \$650,000 by occupied bed days yields \$1,368. These costs are summarized in Table 1. These costs can be compared to the CHAMPUS costs.

CHAMPUS Orthopedics cases for the fiscal year 1993 cost the government \$168,704 for 31 inpatient admissions (see Appendix G, Total All Categories of Beneficiaries section, NAS required). Dividing the total government cost by 31 total admissions yields a \$5,442.00 average government cost per admission. The total occupied bed days is 109. Dividing this by total admissions yields a 3.52 average length of stay or average OBD. Furthermore, dividing \$5,442.00 by the average OBD or length of stay yields a \$1546.00 average government cost per occupied bed day. These costs are also summarized in Table 1.

⁵May [Ref. 8] developed a methodology to estimate cost per admission where admissions involved several work centers. The cost per admission is determined from the treatment protocols and the cost per OBD for each work center. The cost is estimated as a weighted sum of the cost per OBD in each work center where the weights equal the number of days spent in each work center.

$$\text{Cost for each admission} = w_1 * C_1 + \dots + w_n * C_n \quad i=1 \text{ to } n$$

This methodology is not necessary in this case because orthopedic patients are only treated by one work center.

	Naval Hospital Oak Harbor	CHAMPUS	% Savings
Average Cost per Admission	\$3,266	\$5,442	40%
Average cost per Occupied Bed Day	\$1,368	\$1546	12%
Average Occupied Bed Day per Admission	2.39	3.52	32%

**Table 1. Orthopedic Cost Comparison
between Direct Care and CHAMPUS for Naval Hospital,
Oak Harbor Catchment Area**

IV. DISCUSSION AND RECOMMENDATIONS

A. SUMMARY

The data derived from the Cost Comparison Summary can be used to calculate the final costs and work-load for Orthopedic care incurred at Naval Hospital Oak Harbor and CHAMPUS for FY 1993. Referring to Appendix I, the average cost per admission at the MTF level is about \$3,266. This represents the average cost for inpatient care for one Orthopedic specialty patient. It is derived by multiplying the average cost per occupied bed day, \$1,369, by the average length of stay, 2.39 days. The CHAMPUS cost for Orthopedic care per admission within the Oak Harbor catchment area is \$5,442. This number is derived from the CHAMPUS Health Care Summary Report.

This indicates there is a significant cost difference between the two programs. Assuming the cost per patient is unaffected by shifting the workload from CHAMPUS to the MTF, \$2,172 per patient represents a substantial savings.

Based on the data analyzed in this research, shifting CHAMPUS Orthopedics cases back to the Naval Hospital Oak Harbor could have significantly reduced the overall Orthopedic cost for the Oak Harbor catchment area for FY 1993. The potential savings represents almost a 40 percent reduction in the total CHAMPUS cost in all Orthopedic categories in the Oak Harbor area. The average MTF cost per OBD was 12 percent lower than the average CHAMPUS cost per OBD. The total savings exceeds the savings per OBD because MTF patients have a 32 percent lower average OBD per admission than CHAMPUS patients.

It should be noted that the remaining five medical specialties within the Naval Hospital Oak Harbor were not compared and analyzed. Thus, the potential savings from these specialties and their impact on the overall CHAMPUS costs for the catchment area cannot be ascertained. The

other five medical specialties must be considered before drawing any conclusions about bringing orthopedic patients back into the MTF. If the MTF's total resources are limited, it should focus on those specialties providing the greatest cost savings. It would be inefficient for the MTF to use its limited resources to bring orthopedics back into the MTF if it could realize greater cost savings in other specialties.

Actual versus Estimated Cost Savings

There are extra costs associated with shifting any form of medical specialty. These costs may be significant. Examples of these costs are salaries of new doctors, additional ancillary costs, and other support costs. One way to forecast future cost when shifting patients is to use the established average cost per patient per occupied bed day. This represents the average cost incurred by the military hospital for doctors' salaries, ancillary services, and other support services for that work center.

When deciding to bring workload into the MTF one must consider the average cost versus the marginal cost. Using average costs to forecast the impact of shifting workloads implies that the rates of doctors, staff, support services, equipment, facilities, etc. per patient remain constant as the number of patients changes. If increasing the workload allows the MTF to use existing assets more efficiently, average cost will overstate the actual incremental cost of adding patients. If increasing the workload requires acquiring new assets (doctors, staff, equipment, etc.) average cost may understate the actual incremental cost of adding patients. Ideally, this analysis would compare the incremental cost of shifting workloads from CHAMPUS to the MTF. Unfortunately, incremental cost data is unavailable so average cost data is used as a proxy. It is unclear whether average cost is a good or bad proxy in this case.

Furthermore, there may be reasons for referring some CHAMPUS Orthopedic patients to civilian facilities that may help explain the cost differences between CHAMPUS and the MTF within the Oak Harbor catchment area. Some patients may require specialized equipment or medical staff unavailable at the MTF. Similarly, some severe cases may exceed the MTF's capabilities. To the extent that CHAMPUS patients reflect these factors, the cost savings would be overestimated here. Unfortunately, existing data does not reflect these factors. They must be determined on a case by case basis.

There are several other factors that make it difficult to estimate potential savings from shifting workload from CHAMPUS to the MTF. First, the potential savings that could be derived from shifting CHAMPUS workload depends upon the patients' private insurance coverage. For eligible family members who have private insurance, CHAMPUS is considered a secondary insurer. Therefore, it only pays charges not covered by the family members' insurance. This must be weighed against the insurance implications of recapturing the patient in the MTF. [Ref. 17:pp. 4-8]

Second, it is important to consider the potential effect on the quality of medical care and the population's overall satisfaction. Increasing the number of patients seen within a particular specialty may reduce access to that health care service. This may be observed in terms of both longer lines (waiting to make an appointment or follow-up) and the amount of time physicians spend with their patients. In addition, patients no longer have the option to see any specialist or doctor they choose (exceptions are emergency conditions). This may increase patient dissatisfaction and reduce actual or perceived quality.

Another issue to consider is the effect on the regional health care system outside the MTF. Effective, 01 March

1995, the Managed Care Support (MCS) contract will be implemented in the Washington/Oregon catchment areas. In this contract, the government has attempted to "fix" the contract cost. The objective is to reduce the contractor's risk due to changes in the actual workload. For cost elements where cost is fixed, the MCS contract includes a Bid Price and Bid Price Adjustment Formula. The Bid Price represents a fee-for-service rate. It is based on the projected CHAMPUS population and case mix. The Bid Price Adjustment formula adjusts the fee-for-service rate based on the actual CHAMPUS population case mix, CHAMPUS reimbursement policy and MTF utilization rate.

Normally, the contractor's revenue and profit would depend on its caseload and case mix. The contractor's profits could be at risk as its case load increased or decreased. To limit this risk, health care service prices will be adjusted to account for differences between the actual and projected levels of MTF utilization. Further, the contractor's expected level of inpatient costs may be influenced by shifts in inpatient casemix between CHAMPUS and the MTFs. Therefore, the bid prices for inpatient care will also be adjusted for changes in the CHAMPUS inpatient casemix, provided the smaller of the two changes in casemix reflects at least a two percent change relative to the data collection period.

As DoD "downsizes", the supply of military physicians within Naval Hospital Oak Harbor is limited, not only in Orthopedics, but in most clinical areas. This situation is not unique to Oak Harbor. It is common at other military treatment facilities as well. Some MTF services may have to be cut back, and some closed, due to the lack of resources.

B. CONCLUSIONS

The methodology described in this research provides a best estimate for centrally comparing Orthopedic costs

between a military treatment facility and CHAMPUS. The CHAMPUS cost per patient admission can be derived from the CHAMPUS Health Care Summary Report. The military treatment facility cost can be constructed using the cost per occupied bed day estimates from MEPRS. Since the data used in this analysis is based on average cost, Orthopedics appears to be lower at the MTF than through CHAMPUS.

The MEPRS data measures average cost. Average cost is the only data that is available. However, decisions to shift patients between the MTF and CHAMPUS should be based on incremental cost. Accuracy is also a question. It is a function of the individuals providing the data. The reliability of the data has been questioned. Another cost implication that must be examined is the acuity of the patients being referred. If more critical patients are being referred to civilian providers, it could explain the higher CHAMPUS cost. Finally, to maximize limited resources, the remaining five specialty areas must be examined. It could be more cost effective to bring other specialty care back into the MTF. Because of these considerations, it is difficult to recommend bringing Orthopedic patients back into the MTF based on the cost data available.

Centralized data, as currently collected, can not be used to make or monitor cost effective decisions. Each command has local knowledge about individual facility capabilities that are not captured in statistical information and data. This data is critical for making appropriate decisions.

Ensuring correct decisions requires making these decisions at the local level. BUMED has started encouraging this by allowing commanding officers to make decisions if they can justify savings and manage the funding provided. If commanding officers are going to make prudent and

appropriate decisions, better information must be provided. In addition, MTF CO's must have appropriate incentives to manage direct dollars and CHAMPUS targets. The "triple option" and capitated budgets are a move in the right direction. When specific incentive systems are established, the system should be designed to encourage commanding officers to even go below target if quality is not compromised.

C. RECOMMENDATIONS

This research has analyzed and compared the costs of one medical specialty, Orthopedics, between a military treatment facility and its catchment area. Based on the average cost data analyzed, it appears that a significant savings could be realized by shifting patients back to the MTF. However, before attempting to shift major CHAMPUS workloads, a further study should be conducted on the other five specialties. This study would ascertain the full impact of possible changes in all specialty areas. It would help ensure appropriate changes are made.

When shifting CHAMPUS costs back to the MTF, commanding officers need to have the latitude to identify appropriate shifts, in concert with the Lead Agent. In order for the commanding officers to make the appropriate decision, an incentive system needs to be established that will encourage efficiency without future penalties (e.g. lowering the capitated rate or CHAMPUS target). To support the commanding officers in the decision making, appropriate data systems must be developed and accurate information has to flow freely. Data that is currently being used in the decision process is sometimes less than accurate and may measure the wrong inputs.

It should be noted that data utilized in this research was only based on beneficiaries using Standard CHAMPUS. This catchment area signed a TRICARE contract in October

1994 which will go into effect in March 1995. The contract will offer beneficiaries the "triple option". This is expected to provide a CHAMPUS cost savings in the future and could even further reduce specialty care cost. The "triple option's" cost impact should be monitored closely.

D. AREAS FOR FUTURE RESEARCH

1. Analyze the cost of the remaining five medical specialties at Naval Hospital Oak Harbor. Such a study should cover a two to three year span in order to determine if there is a continuous trend in MTF versus CHAMPUS costs.
2. Evaluate the Managed Care "Triple Option" program after the program has been implemented for at least one year. The study should ascertain if it is prudent to recapture patients or refer them to the contractor. The study should also evaluate DoD's financial impact of recapturing patients under the BID Price Adjustment Methodology.
3. Analyze the cost implications of recapturing patients that are not reflected in the current cost data. Some of these cost factors include:
 - patient severity
 - MTF resource availability
 - MTF capabilities
4. Examine Incentives at all levels (e.g, physicians, COs, Lead Agents, BUMED, patients, etc) to ensure that all stakeholders are encouraged to minimize health care cost while maintaining quality. Cost minimization requires each stakeholder to make the appropriate decision.
5. Examine procedures for setting capitated rates and CHAMPUS targets. Do these procedures encourage local decision makers to minimize the overall cost of medical care in their catchment area?

If not, how can they be modified.

6. Identify the data required to make appropriate decisions at each level. How should DoD's health care information system be modified to facilitate the decision making process.

APPENDIX A
EXAMPLE OF PERFORMANCE DESCRIPTIONS
NAVAL HOSPITAL OAK HARBOR, FY 93

<u>ACCT</u>	<u>DESCRIPTION</u>	<u>PERFORMANCE DESCRIPTION</u>
DAA	PHARMACY	WEIGHTED PROCEDURE
DBA	CLINICAL PATHOLOGY	WEIGHTED PROCEDURE
DBC	BLOOD BANK	WEIGHTED PROCEDURE
DCA	RADIOLOGY	WEIGHTED PROCEDURE
DDA	ELECTROCARDIOLOGY	PROCEDURE
DDD	PULMONARY FUNCTION	WEIGHTED PROCEDURE
DEA	CENTRAL STERILE SUPPLY	HOURS OF SERVICE
DFA	ANESTHESIOLOGY	MINUTES OF SERVICE
DFB	SURGICAL SUITE	MINUTES OF SERVICE
DHD	PHYSICAL THERAPY	VISIT
DGA	SAME DAY SURGERY	MINUTES OF SERVICE

APPENDIX B

STATISTICAL DATA SET (OCCUPIED BED DAY DATA) NAVAL HOSPITAL, OAK HARBOR, FY 1993

UCA CODE	QTR 1	QTR 2	QTR 3	QTR 4
AAAA	41	23	2	8
ABAA	266	233	161	107
ACAA	65	52	47	27
ACBA	341	289	303	208
ADAA	64	77	83	38
ADBA	271	254	256	254
AEAA	95	124	94	49
AGAA	91	95	97	111
AGCA	51	34	44	40
AGDA	24	44	20	29
AGEA	3	0	0	0
AGHA	26	17	34	24

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR

FACILITY CODE: 066097

DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93

PAGE 1-1

ACCT	DES PAGE 1 AMOUNT	DES PAGE 2 AMOUNT	DES PAGE 3 AMOUNT	DES PAGE 30 AMOUNT	DES PAGE 31 AMOUNT	DES PAGE 32 AMOUNT	TOTAL
EDBA	0	105980	0	0	0	0	105980
EDCA	0	7746	0	0	0	0	7746
EDDA	0	236	0	0	0	0	236
EDEA	0	7197	0	0	0	0	7197
EDGA	0	18867	0	0	0	0	18867
EDJA	0	98850	0	0	0	0	98850
EBAA	0	171885	0	0	952001	0	1123886
EBBA	0	177172	0	0	359056	0	536228
EBCA	0	202885	0	0	954262	0	1157147
EBDA	0	19886	0	0	245724	0	265610
EBFA	0	36752	0	0	118601	0	155353
EBGA	0	25	0	0	2191	0	2216
EBHA	0	34300	0	0	30419	0	64719
EEAA	0	134371	0	0	299142	0	433513
EFAA	0	280469	0	0	166074	0	446543
EGAA	0	7026	0	0	113110	0	120136
EHBA	0	48990	0	0	0	0	48990
EIBA	0	20075	0	0	0	0	20075
EIAA	0	32	0	0	0	0	32
EJAA	0	155675	0	0	505326	0	661001
EKAA	0	204185	0	0	186230	0	390415
DEAA	0	42314	0	0	28883	0	71197
DEBA	0	248056	0	0	27750	0	275806
DAAA	1793900	0	0	452633	0	0	2246533
DBAA	502798	0	0	388003	0	0	890801
DBCA	0	0	0	34389	0	0	34389
DCAA	0	550168	0	0	188957	0	739125
DCAE	0	0	0	0	0	0	0
DDAA	0	0	0	0	1028	0	1028
DDDA	0	1949	0	0	1943	0	3892
DFAA	0	15935	0	0	305815	0	321750
DFBA	0	159976	0	0	422598	0	582574
DFCA	0	0	0	0	85853	0	85853
AAAA	0	0	0	1937	0	0	1937
AAXS	208356	0	0	782773	0	0	991129
ABAA	0	0	0	52344	0	0	52344
ABEA	0	0	0	0	0	0	0
ACAA	0	0	0	0	0	0	0
ACBA	0	0	0	38	0	0	38
ACX0	177163	0	0	806375	0	0	983538

PREPARED: 94 OCT 04 1542 HRS DIRECT EXPENSE SUMMARY
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097
DOD REGION: 11

PCN NAA-Q08

QUARTER 4 : 01 JUL - 30 SEP FY 93
PAGE 1-2

ACCT	DES PAGE 1 AMOUNT	DES PAGE 2 AMOUNT	DES PAGE 3 AMOUNT	DES PAGE 30 AMOUNT	DES PAGE 31 AMOUNT	DES PAGE 32 AMOUNT	TOTAL
ADAA	0	0	0	4633	0	0	4633
ADBA	116565	0	0	25022	0	0	141587
AEAA	0	0	0	23234	0	0	23234
AGAA	0	0	0	10336	0	0	10336
AGBA	0	0	0	0	0	0	0
AGCA	0	0	0	11690	0	0	11690
AGDA	0	0	0	6916	0	0	6916
AGEA	0	0	0	0	0	0	0
AGHA	0	0	0	10863	0	0	10863
BAAA	18027	0	0	95250	0	0	113277
BALA	23364	0	0	0	0	0	23364
BBAA	38371	0	0	144505	0	0	182876
BCBA	0	0	0	0	0	0	0
BCCA	0	0	0	0	0	0	0
BCXO	0	0	0	0	0	0	0
BDAA	2124843	0	0	0	0	0	2124843
BEAA	1306	0	0	274968	0	0	276274
BFAA	28836	0	0	122277	0	0	151113
BFAA	59917	0	0	236811	0	0	296728
BFAA	168350	0	0	185867	0	0	354217
BFEA	127311	0	0	72058	0	0	199369
BGAA	106252	0	0	634590	0	0	740842
BHAA	105	0	0	284902	0	0	285007
BHAE	3046	0	0	0	0	0	3046
BHCA	25274	0	0	222309	0	0	247583
BHGA	153004	0	0	138481	0	0	291485
BIAA	1958090	0	0	0	0	0	1958090
BJAA	13928	0	0	539426	0	0	553354
BLAA	17670	0	0	31794	0	0	49464
FAIA	0	54399	0	0	470737	0	525136
FALA	0	122479	0	0	225445	0	347924
FBBA	0	37397	0	0	187089	0	224486
FBCA	0	114295	0	0	99260	0	213555
FBIA	0	130760	0	0	34586	0	165346
FCAA	0	94158	0	0	0	0	94158
FCCA	0	27474	0	0	66543	0	94017
FCDA	0	0	8436	0	203854	0	212290
FEAA	0	0	8903	0	388206	0	397109
FIAA	0	0	0	0	0	716	716
FJAG	0	0	3042	0	0	21596	24638
TOTAL	7666476	3331964	20381	5594424	6670683	22312	23306240

STEPDOWN SCHEDULE (APPENDIX D)

PREPARED: 94 OCT 04 1542 HRS
 FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
 FACILITY CODE: 066097
 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
 PAGE 1 - 1

ACCT DESCRIPTION	DIRECT EXPENSE	EDBA	EDCA	EDDA	EDEA	EDGA	EDJA	FBAF
EDBA OPERATION OF UTILITIES	105980	105980	0	0	0	0	0	0
EDCA MAINTENANCE OF REAL PROPERTIES	7746	0	7746	0	0	0	0	0
EDDA MINOR CONSTRUCTION	236	0	0	236	0	0	0	0
EDEA OTHER ENGINEERING SUPPORT	7197	0	0	0	7197	0	0	0
DGA TRANSPORTATION	18867	0	0	0	0	18867	0	0
DJA COMMUNICATIONS	98850	0	0	0	0	0	98850	0
BAA CO-XO-MASTER CF & THEIR STAFF	1123886	13192	629	0	895	4459	4799	1194/0
BBA INTERNAL REVIEW - QUALITY ASSURANCE	536228	452	0	0	31	0	1896	231
BBCA FISCAL/MANPOWER/OFFICE SERVICES	1157147	69021	6763	228	4687	13373	7080	864
BDA CLINICAL MANAGEMENT	265610	13843	157	0	940	0	839	102
BBA EDUCATION AND TRAINING PROGRAM SUPP	155353	4637	0	0	315	3	847	103
BBA PEACETIME EXERCISES/DISASTER PREPAR	2216	0	0	0	0	0	11	1
BBA THIRD PARTY COLLECTION	64719	0	0	0	0	0	254	31
EAA MATERIEL SERVICES	433513	378	19	1	26	151	2531	308
FAA HOUSEKEEPING AND JANITORIAL SERVICE	446543	228	0	0	15	0	1891	230
GAA BIOMEDICAL EQUIPMENT REPAIR	120136	101	0	0	7	0	856	104
HBBA LINEN AND LAUNDRY SERVICE	48990	26	0	0	2	0	0	0
FIBA SUBSISTENCE	20075	0	0	0	0	0	0	0
IAA DIETETICS	32	0	0	0	0	0	0	0
JAA INPATIENT CARE ADMINISTRATION	661001	28	1	0	2	0	4019	490
KAA AMBULATORY CARE ADMINISTRATION	390415	106	0	0	0	0	1799	219
DEAA CENTRAL STERILE SUPPLY	71197	114	0	0	0	0	220	26
EBA PHARMACY	275806	18	10	0	11	0	282	34
BAA CLINICAL PATHOLOGY	2246533	161	3	1	10	3	4222	515
BBCA BLOOD BANK	890801	149	31	1	5	0	3051	372
ICAA DIAGNOSTIC RADIOLOGY	34389	66	7	0	11	0	311	272
ICAE RADIOLOGY CONTRAST	739125	167	0	0	0	0	2242	100
IDAA ELECTROCARDIOGRAPHY	0	0	0	0	0	0	824	1
DDA PULMONARY FUNCTION	1028	8	0	0	0	0	9	17
FAA ANESTHESIOLOGY	3892	57	0	0	4	0	17	110
FBA SURGICAL SUITE	321750	57	0	0	4	0	904	37
FCA RECOVERY ROOM	582574	170	1	2	12	0	3061	5
AAA INTERNAL MEDICINE	85853	57	0	0	4	0	435	5
AXS WARD G COST POOL	1937	0	0	0	0	0	5	614
BAA GENERAL SURGERY	991129	343	21	1	23	0	5039	20
BEA OPHTHALMOLOGY	52344	0	0	0	0	0	167	0
CAA GYNECOLOGY	0	0	0	0	0	0	0	11
CBA OBSTETRICS	38	0	0	0	0	0	96	11
CXO WARD H COST POOL	983538	275	17	0	19	0	9580	116

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ACCT DESCRIPTION	DIRECT EXPENSE	EDBA	EDCA	EDDA	EDEA	EDGA	EDJA	FBA
ADAA PEDIATRICS	4633	0	0	0	0	0	13	1
ADBA NURSERY	141587	150	0	0	0	0	68	1
AEAA ORTHOPEDICS	23234	0	0	0	10	0	50	1
AGAA FAMILY PRACTICE INTERNAL MEDICINE	10336	0	0	0	0	0	36	1
AGBA FAMILY PRACTICE SURGERY	0	0	0	0	0	0	0	1
AGCA FAMILY PRACTICE OBSTETRICS	11690	0	0	0	0	0	47	1
AGDA FAMILY PRACTICE PEDIATRICS	6916	0	0	0	0	0	26	1
AGEA FAMILY PRACTICE GYNECOLOGY	0	0	0	0	0	0	0	1
AGHA FAMILY PRACTICE NURSERY	10863	0	0	0	0	0	27	1
AGHA INTERNAL MEDICINE CLINIC	113277	58	0	0	0	0	399	1
BAAA NUTRITION CLINIC	23364	82	0	0	0	0	66	1
BALA GENERAL SURGERY CLINIC	182876	50	24	1	4	0	613	1
BBAA GYNECLOGY CLINIC	0	94	0	0	6	0	0	1
BCBA OBSTETRICS CLINIC	0	94	0	0	6	0	0	1
BCXO OB GYN COST POOL	2124843	0	0	0	0	0	3148	1
BDAA PEDIATRIC CLINIC	276274	76	0	0	0	0	1129	1
BEAA ORTHOPEDIC CLINIC	151113	49	0	0	0	0	555	1
BFAA PSYCHIATRY CLINIC	296728	102	9	0	7	0	1152	1
BFAX CHAMPUS RECOUP	354217	0	0	0	0	0	422	1
BFEA SOCIAL WORK SERVICES	199369	103	2	0	7	0	3275	1
BGAA FAMILY PRACTICE CARE	740842	256	1	0	0	0	1619	1
BHAA PRIMARY CARE CLINICS	285007	53	2	0	4	0	2977	1
BHAE PRIMARY CARE CLINIC CONTRACT	3046	135	0	0	9	0	1596	1
BHCA OPTOMETRY CLINIC	247583	178	0	0	12	0	852	1
BHGA OCCUPATIONAL HEALTH CLINIC	291485	126	0	0	9	0	6560	1
BIAA EMERGENCY MEDICAL CARE	1958090	225	25	0	15	0	2402	1
BJAA FLIGHT MEDICINE CARE	553354	134	17	0	9	0	338	1
BLAA PHYSICAL THERAPY	49464	0	0	0	0	0	3576	1
FAIA PHYSIOLOGICAL TRAINING/SUPPORT PROG	525136	287	7	1	19	0	1290	1
FALA TRAINING EXTERNALLY SPONSORED CHE	347924	0	0	0	0	0	1399	1
FBBA PREVENTIVE MEDICINE	224486	21	0	0	2	0	435	1
FBCA INDUSTRIAL HYGIENE	213555	23	0	0	2	0	477	1
FBIA IMMUNIZATIONS	165346	22	0	0	1	0	0	1
FCAA SUPPLEMENTAL CARE PURCHASED FROM CI	94158	0	0	0	0	0	469	1
FCCA CHAMPUS BENEFICIARY SUPPORT	94017	8	0	0	1	0	1614	1
FCDA SUPPORT TO OTHER MILITARY ACTIVITIES	212290	0	0	0	0	0	3620	1
FEAA PATIENT TRANSPORTATION	397109	0	0	0	0	0	5	1
FIAA READINESS TRAINING LOCAL	716	0	0	0	0	0	101	1
FJAG MILITARY TRAVEL SOMOLIA	24638	0	0	0	0	0	0	1
	23306240	0	0	0	0	878	0	1

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ACCT	EBBA	EBCA	EBDA	EBFA	EBGA	EBHA	EEAA	EFAA	EGAA	EHBA	EIN
EDBA	0	0	0	0	0	0	0	0	0	0	0
EDCA	0	0	0	0	0	0	0	0	0	0	0
EDDA	0	0	0	0	0	0	0	0	0	0	0
EDEA	0	0	0	0	0	0	0	0	0	0	0
EDGA	0	0	0	0	0	0	0	0	0	0	0
EDJA	0	0	0	0	0	0	0	0	0	0	0
EBAA	0	0	0	0	0	0	0	0	0	0	0
EBBA	561752	0	0	0	0	0	0	0	0	0	0
EBCA	43157	1387863	0	0	0	0	0	0	0	0	0
EBDA	5112	13680	310416	0	0	0	0	0	0	0	0
EBFA	5163	13819	0	190475	0	0	0	0	0	0	0
EBGA	71	191	0	26	2658	0	0	0	0	0	0
EBHA	1550	4146	0	581	8	74360	0	0	0	0	0
EEAA	15425	41282	0	5780	80	0	530071	0	0	0	0
EFAA	11526	30846	0	4319	61	0	3255	521760	153067	0	0
EGAA	5222	13974	0	1957	27	0	332	0	0	0	0
EHBA	0	0	0	0	0	0	1444	0	0	50462	20
EIBA	0	0	0	0	0	0	0	0	0	0	0
EIAA	0	0	0	0	0	0	5	0	0	0	0
EJAA	24495	65554	0	9178	128	0	303	5504	0	0	0
EKAA	10966	29346	0	4109	57	0	26	5505	0	0	0
DEAA	1344	3598	0	504	7	0	935	22580	11087	0	0
DEBA	1717	4596	0	644	9	0	25808	0	0	0	0
DAAA	25740	6883	0	9644	135	0	192283	16000	2772	0	0
DBAA	18598	49773	0	6970	97	0	36972	8436	7096	0	0
DBCA	1893	5066	0	709	10	0	0	8436	2828	0	0
DCAA	13666	36574	0	5121	72	0	17608	14154	7928	5051	0
DCAE	5021	13436	0	1881	26	0	0	0	0	0	0
DDAA	57	152	0	21	0	0	0	0	0	0	0
DDDA	102	272	0	39	1	0	0	11290	0	0	0
DFAA	5511	14749	0	2065	28	0	994	11290	4989	0	0
DFBA	18662	49943	0	6993	98	0	17309	11289	11143	0	0
DFCA	2647	7086	0	992	14	0	0	11290	2606	0	0
AAAA	36	96	41	13	0	0	0	0	0	0	0
AXXS	30714	82196	35953	11509	161	0	2508	67894	6708	7577	4
ABAA	1016	2720	1345	381	5	0	0	0	0	10103	4
ABEA	0	0	0	0	0	0	0	0	0	0	1
ACAA	585	1564	746	219	3	0	0	0	0	0	7
ACBA	579	1550	678	217	3	0	0	0	0	0	0
ACX0	58403	156298	68365	21884	306	0	4736	54423	5710	15154	0

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ACCT	EIAA	EJAA	EKAA	DEAA	DEBA	DAAA	DBAA	DBCA	DCAA	DCAE
EDBA	0	0	0	0	0	0	0	0	0	0
EDCA	0	0	0	0	0	0	0	0	0	0
EDDA	0	0	0	0	0	0	0	0	0	0
EDEA	0	0	0	0	0	0	0	0	0	0
EDGA	0	0	0	0	0	0	0	0	0	0
EDJA	0	0	0	0	0	0	0	0	0	0
EBAA	0	0	0	0	0	0	0	0	0	0
EBBA	0	0	0	0	0	0	0	0	0	0
EBCA	0	0	0	0	0	0	0	0	0	0
EBDA	0	0	0	0	0	0	0	0	0	0
EBFA	0	0	0	0	0	0	0	0	0	0
EBGA	0	0	0	0	0	0	0	0	0	0
EEAA	0	0	0	0	0	0	0	0	0	0
EFAA	0	0	0	0	0	0	0	0	0	0
EGAA	0	0	0	0	0	0	0	0	0	0
EHBA	0	0	0	0	0	0	0	0	0	0
EIBA	0	0	0	0	0	0	0	0	0	0
EIAA	37	819257	0	0	0	0	0	0	0	0
EJAA	0	0	464290	114286	0	0	0	0	0	0
EKAA	0	0	0	0	312319	2618792	1065968	62397	871449	0
DEAA	0	0	0	0	863	0	4862	0	0	0
DEBA	0	0	0	0	6772	0	0	2118	0	33358
DAAA	0	0	0	0	1071	1271	0	0	0	0
DBAA	0	0	0	0	0	0	0	0	0	0
DBCA	0	0	0	19	0	0	0	0	0	0
DCAA	0	0	0	0	0	0	0	0	0	0
DCAE	0	0	0	0	0	0	0	0	0	0
DDAA	0	0	0	0	0	0	0	0	0	0
DDDA	0	0	0	0	13161	41095	0	0	0	0
DFAA	0	0	0	59351	29554	60817	0	0	0	0
DFBA	0	0	0	0	6792	32662	0	0	0	0
DFCA	0	0	0	0	0	29616	658	49	0	0
AAAA	0	13133	0	0	0	55799	32865	850	11316	433
AAAS	0	0	0	939	41906	62382	0	0	7478	286
ABAA	8	136129	0	0	0	0	0	0	0	0
ABEA	0	0	0	0	0	22464	3668	514	922	35
ACAA	2	33899	0	0	0	15804	21796	11602	1689	65
ACBA	13	202507	0	0	0	42869	0	0	1044	40
ACX0	0	0	0	14683	52056	0	0	0	0	0

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CT	DDDA	DFAA	DFBA	DFCA	TOTAL EXPENSE
00BA	0	0	0	0	0
01CA	0	0	0	0	0
02DA	0	0	0	0	0
03EA	0	0	0	0	0
04GA	0	0	0	0	0
05JA	0	0	0	0	0
06AA	0	0	0	0	0
07BA	0	0	0	0	0
08CA	0	0	0	0	0
09DA	0	0	0	0	0
10FA	0	0	0	0	0
11GA	0	0	0	0	0
12HA	0	0	0	0	0
13AA	0	0	0	0	0
14AA	0	0	0	0	0
15AA	0	0	0	0	0
16BA	0	0	0	0	0
17BA	0	0	0	0	0
18AA	0	0	0	0	0
19AA	0	0	0	0	0
20AA	0	0	0	0	0
21AA	0	0	0	0	0
22BA	0	0	0	0	0
23BA	0	0	0	0	0
24AA	0	0	0	0	0
25AA	0	0	0	0	0
26AA	0	0	0	0	0
27BA	0	0	0	0	0
28AA	0	0	0	0	0
29AE	0	0	0	0	0
30AA	0	0	0	0	0
31DA	15878	0	0	0	114286
32AA	0	427631	0	0	312319
33BA	0	0	0	0	2617929
34CA	0	0	0	0	1059196
35AA	0	0	0	0	57535
36CA	0	0	0	0	869088
37AE	0	0	0	0	31240
38AA	0	0	0	0	1389
39DA	0	0	0	0	15878
40AA	0	427631	0	0	373375
41BA	0	0	0	0	738620
42CA	0	0	888342	0	116286
43AA	0	0	0	155740	46004
44AA	0	0	0	0	1413663
45XS	0	0	0	0	827143
46AA	0	150815	309833	52140	0
47EA	0	0	0	0	0
48AA	0	82454	140310	40507	330248
49BA	0	100078	97173	33011	495086
50X0	0	0	0	0	1606332

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ACCT	DDDA	DFAA	DFBA	DFCA	TOTAL EXPENSE
ADAA	0	0	0	0	70663
ADBA	0	0	0	0	422277
AEAA	0	88152	246818	24153	468614
AGAA	0	0	0	0	91141
AGBA	0	0	0	0	2064
AGCA	0	0	0	0	47598
AGDA	0	0	0	0	30925
AGEA	0	0	0	0	564
AGHA	0	0	0	0	30010
BAAA	0	0	0	0	218325
BALA	0	0	0	0	42986
BBAA	0	302	87816	5461	401280
BCBA	0	0	0	0	229628
BCCA	0	0	0	0	379526
BCXO	0	0	0	0	2409463
BDAA	0	0	0	0	458498
BEAA	0	0	4248	0	251104
BFAA	0	0	0	0	385206
BFAX	0	0	0	0	411637
BFEA	0	0	0	0	240685
BGAA	0	0	0	0	1733182
BHAA	0	0	0	0	658406
BHAE	0	0	0	0	780629
BHCA	0	0	0	0	371296
BHGA	0	0	0	0	446580
BIAA	15878	0	0	0	3304428
BJAA	0	0	0	0	1122366
BLAA	0	0	0	0	94943
LAIA	0	0	0	0	661418
ALAA	0	0	0	0	396865
BBA	0	0	0	0	287853
FBCA	0	0	0	0	232662
FBIA	0	0	0	0	205844
FCAA	0	0	0	0	94158
FCCA	0	0	0	0	690665
FCDA	0	5830	2144	468	349149
FEAA	0	0	0	0	535755
IAA	0	0	0	0	921
JAG	0	0	0	0	28450
					23306240

FINAL PURIFICATION (APPENDIX E)

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ACCT DESCRIPTION	EXP. AFT. STEPDOWN	AAXS	ACX0	BCX0	AMOUNT REASSGND	PURIFIED EXPENSE
AAAA INTERNAL MEDICINE	46004	51119	0	0	51119	97123
AAXS WARD G COST POOL	1413663	1413663-	0	0	1413663-	0
ABAA GENERAL SURGERY	827143	502680	0	0	502680	1329823
ABEA OPHTHALMOLOGY	0	0	0	0	0	0
ACAA GYNECOLOGY	330248	122557	4973	0	127530	457778
ACBA OBSTETRICS	495086	69470	1408648	0	1478118	1973204
ACXO WARD H COST POOL	1606332	0	1606332-	0	1606332-	0
ADAA PEDIATRICS	70663	96342	0	0	96342	167005
ADBA NURSERY	422277	0	0	0	0	422277
AEAA ORTHOPEDICS	468614	237249	0	0	237249	705863
AGAA FAMILY PRACTICE INTERNAL MEDICINE	91141	258221	0	0	258221	349362
AGBA FAMILY PRACTICE SURGERY	2064	0	0	0	0	2064
AGCA FAMILY PRACTICE OBSTETRICS	47598	9175	192711	0	201886	249484
AGDA FAMILY PRACTICE OBSTETRICS	30925	64883	0	0	64883	95808
AGEA FAMILY PRACTICE PEDIATRICS	564	1967	0	0	1967	2531
AGHA FAMILY PRACTICE GYNECOLOGY	30010	0	0	0	0	30010
AGHA FAMILY PRACTICE NURSERY	218325	0	0	0	0	218325
BAAA INTERNAL MEDICINE CLINIC	42986	0	0	0	0	42986
BALA NUTRITION CLINIC	401280	0	0	0	0	401280
BBAA GENERAL SURGERY CLINIC	229628	0	0	0	0	1553354
BCBA GYNECOLOGY CLINIC	379526	0	0	0	1323726	1465263
BCCA OBSTETRICS CLINIC	2409463	0	0	0	1085737	0
BCXO OB GYN COST POOL	458498	0	0	2409463-	2409463-	0
BDAA PEDIATRIC CLINIC	251104	0	0	0	0	458498
BEAA ORTHOPEDIC CLINIC	385206	0	0	0	0	251104
BFAA PSYCHIATRY CLINIC	411637	0	0	0	0	385206
BFAX CHAMPUS RECUP	240685	0	0	0	0	411637
BFEA SOCIAL WORK SERVICES	1733182	0	0	0	0	240685
BGAA FAMILY PRACTICE CARE	658406	0	0	0	0	1733182
BHAA PRIMARY CARE CLINICS	780629	0	0	0	0	658406
BHAE PRIMARY CARE CLINIC CONTRACT	371296	0	0	0	0	780629
BHCA OPTOMETRY CLINIC	446580	0	0	0	0	371296
BHGA OCCUPATIONAL HEALTH CLINIC	3304428	0	0	0	0	446580
BIAA EMERGENCY MEDICAL CARE	1122366	0	0	0	0	3304428
BJAA FLIGHT MEDICINE CARE	94943	0	0	0	0	1122366
BLAA PHYSICAL THERAPY	661418	0	0	0	0	94943
FAIA PHYSIOLOGICAL TRAINING/SUPPORT PROG	396865	0	0	0	0	661418
FALA TRAINING EXTERNALLY SPONSORED CHE	287853	0	0	0	0	396865
FBBA PREVENTIVE MEDICINE	232662	0	0	0	0	287853
FBCA INDUSTRIAL HYGIENE	205844	0	0	0	0	232662
FBIA IMMUNIZATIONS		0	0	0	0	205844

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ACCT DESCRIPTION	EXP. AFT. STEPDOWN	AAXS	ACXO	BCXO	AMOUNT REASSGND	PURIFIED EXPENSE
FCAA SUPPLEMENTAL CARE PURCHASED FROM CI	94158	0	0	0	0	94158
FCCA CHAMPUS BENEFICIARY SUPPORT	690665	0	0	0	0	690665
FCDA SUPPORT TO OTHER MILITARY ACTIVITIE	349149	0	0	0	0	349149
FEAA PATIENT TRANSPORTATION	535755	0	0	0	0	535755
FIAA READINESS TRAINING LOCAL	921	0	0	0	0	921
FJAG MILITARY TRAVEL SOMOLIA	28450	0	0	0	0	28450
	23306240	0	0	0	0	23306240

COMPUTATION SUMMARY (APPENDIX F)

PREPARED: 94 OCT 04 1542 HRS
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ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
A	2238245	1735737	1908350	5882332	0	5882332
AA	993066	325881	140720	1459667	1362544-	97123
AAA	1937	13740	30327	46004	51119	97123
*AAAA	1937	13740	30327	46004	51119	97123
AAX	991129	312141	110393	1413663	1413663-	0
*AAXS	991129	312141	110393	1413663	1413663-	0
AB	52344	158100	616699	827143	502680	1329823
ABA	52344	158100	616699	827143	502680	1329823
*ABAA	52344	158100	616699	827143	502680	1329823
ABE	0	0	0	0	0	0
*ABEA	0	0	0	0	0	0
AC	983576	765288	682802	2431666	684-	2430982
ACA	0	39364	290884	330248	127530	457778
*ACAA	0	39364	290884	330248	127530	457778
ACB	38	213822	281226	495036	1478118	1973204
*ACBA	38	213822	281226	495036	1478118	1973204
ACX	983538	512102	110692	1606332	1606332-	0
*ACXO	983538	512102	110692	1606332	1606332-	0
AD	146220	268671	78049	492940	96342	589282
ADA	4633	48493	17537	70663	96342	167005
*ADAA	4633	48493	17537	70663	96342	167005
ADB	141587	220178	60512	422277	0	422277
*ADBA	141587	220178	60512	422277	0	422277
AE	23234	68522	376858	468614	237249	705863
AEA	23234	68522	376858	468614	237249	705863
*AEAA	23234	68522	376858	468614	237249	705863
AG	39805	149275	13222	202302	526957	729259
AGA	10336	73840	6965	91141	258221	349362
*AGAA	10336	73840	6965	91141	258221	349362
AGB	0	0	2064	2064	0	2064
*AGBA	0	0	2064	2064	0	2064
AGC	11690	33110	2798	47598	201886	249484
*AGCA	11690	33110	2798	47598	201886	249484
AGD	6916	22630	1379	30925	64883	95808
*AGDA	6916	22630	1379	30925	64883	95808
AGE	0	548	16	564	1967	2531
*AGEA	0	548	16	564	1967	2531
AGH	10863	19147	0	30010	0	30010
*AGHA	10863	19147	0	30010	0	30010
B	7850932	2354290	3734946	13940168	0	13940168
BA	136641	58931	65739	261311	0	261311
BAA	113277	39309	65739	218325	0	218325
*BAAA	113277	39309	65739	218325	0	218325
BAL	23364	19622	0	42986	0	42986
*BALA	23364	19622	0	42986	0	42986

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

COMPUTATION SUMMARY

PCN NAA-Q13

QUARTER 4 : 01 JUL - 30 SEP FY 93
PAGE 02

YEAR TO DATE

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
BB	182876	49344	169060	401280	0	401280
BBA	182876	49344	169060	401280	0	401280
*BBAA	182876	49344	169060	401280	0	401280
BC	2124843	348805	544969	3018617	0	3018617
BCB	0	49431	180197	229628	1323726	1553354
*BCBA	0	49431	180197	229628	1323726	1553354
BCC	0	45136	334390	379526	1085737	1465263
*BCCA	0	45136	334390	379526	1085737	1465263
BCX	2124843	254238	30382	2409463	2409463	0
*BCX0	2124843	254238	30382	2409463	2409463	0
BD	276274	78281	103943	458498	0	458498
BDA	276274	78281	103943	458498	0	458498
*BDAA	276274	78281	103943	458498	0	458498
BE	151113	51309	48682	251104	0	251104
BEA	151113	51309	48682	251104	0	251104
*BEAA	151113	51309	48682	251104	0	251104
BF	850314	179538	7676	1037528	0	1037528
BFA	650945	138222	7676	796843	0	796843
*BFAX	296728	80802	7676	385206	0	385206
BFE	354217	57420	0	411637	0	411637
*BFEEA	199369	41316	0	240685	0	240685
BG	740842	249133	743207	1733182	0	1733182
BGA	740842	249133	743207	1733182	0	1733182
*BGAA	740842	249133	743207	1733182	0	1733182
BH	827121	596405	833385	2256911	0	2256911
BHA	288053	390655	760327	1439035	0	1439035
*BHAA	285007	123606	249793	658406	0	658406
*BHAE	3046	267049	510534	780629	0	780629
BHC	247583	118561	5152	371296	0	371296
*BHCA	247583	118561	5152	371296	0	371296
BHG	291485	87189	67906	446580	0	446580
*BHGA	291485	87189	67906	446580	0	446580
BI	1958090	534824	811514	3304428	0	3304428
BIA	1958090	534824	811514	3304428	0	3304428
*BIAA	1958090	534824	811514	3304428	0	3304428
BJ	553354	163248	405764	1122366	0	1122366
BJA	553354	163248	405764	1122366	0	1122366
*BJAA	553354	163248	405764	1122366	0	1122366
BL	49464	44472	1007	94943	0	94943
BLA	49464	44472	1007	94943	0	94943
*BLAA	49464	44472	1007	94943	0	94943
D	5252948	1054193	260408	6567549	0	0
DA	2246533	371396	863	2618792	0	0
DAA	2246533	371396	863	2618792	0	0
*DAAA	2246533	371396	863	2618792	0	0

COMPUTATION SUMMARY

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93
PAGE 03

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
DB	925190	191541	11634	1128365	0	0
DBA	890801	168395	6772	1065968	0	0
*DBAA	890801	168395	6772	1065968	0	0
DBC	34389	23146	4862	62397	0	0
*DBCA	34389	23146	4862	62397	0	0
DC	739125	161203	4479	904807	0	0
DCA	739125	161203	4479	904807	0	0
*DCAA	739125	161203	4479	904807	0	0
*DCAE	739125	129963	2361	871449	0	0
DD	4920	31240	2118	33358	0	0
DDA	1028	12347	0	17267	0	0
*DDAA	1028	361	0	1389	0	0
DDD	3892	361	0	1389	0	0
*DDDA	3892	11986	0	15878	0	0
DE	347003	11986	0	15878	0	0
DEA	71197	79602	0	426605	0	0
*DEAA	71197	43089	0	114286	0	0
DEB	275806	43089	0	114286	0	0
*DEBA	275806	36513	0	312319	0	0
DF	990177	36513	0	312319	0	0
DFA	321750	238104	0	1471713	0	0
*DFAA	321750	51625	243432	427631	0	0
DFB	582574	51625	54256	427631	0	0
*DFBA	582574	156046	149722	888342	0	0
DFC	85853	156046	149722	888342	0	0
*DFCA	85853	30433	39454	155740	0	0
E	5664740	30433	39454	155740	0	0
EB	3305159	808539	0	0	0	0
EBA	1123886	370225	0	0	0	0
*EBAA	1123886	23974	0	0	0	0
EBB	536228	23974	0	0	0	0
*EBBA	536228	25524	0	0	0	0
EBC	1157147	25524	0	0	0	0
*EBCA	1157147	230716	0	0	0	0
EBD	265610	230716	0	0	0	0
*EBDA	265610	44806	0	0	0	0
EBF	155353	44806	0	0	0	0
*EBFA	155353	44806	0	0	0	0
EBG	2216	35122	0	0	0	0
*EBGA	2216	442	0	0	0	0
EBH	64719	442	0	0	0	0
*EBHA	64719	9641	0	0	0	0
ED	238876	9641	0	0	0	0
EDB	105980	0	0	0	0	0
*EDBA	105980	0	0	0	0	0
EDC	7746	0	0	0	0	0

COMPUTATION SUMMARY

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93
PAGE 04

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
*EDCA	7746	0	0	0	0	0
EDD	236	0	0	0	0	0
*EDDA	236	0	0	0	0	0
EDE	7197	0	0	0	0	0
*EDEA	7197	0	0	0	0	0
EDG	18867	0	0	0	0	0
*EDGA	18867	0	0	0	0	0
EDJ	98850	0	0	0	0	0
*EDJA	98850	0	0	0	0	0
EE	433513	96558	0	0	0	0
EEA	433513	96558	0	0	0	0
*EEAA	433513	96558	0	0	0	0
EF	446543	75217	0	0	0	0
EFA	446543	75217	0	0	0	0
*EFAA	446543	75217	0	0	0	0
EG	120136	32931	0	0	0	0
EGA	120136	32931	0	0	0	0
*EGAA	120136	32931	0	0	0	0
EH	48990	1472	0	0	0	0
EHB	48990	1472	0	0	0	0
*EHBA	48990	1472	0	0	0	0
EI	20107	5	0	0	0	0
EIA	32	5	0	0	0	0
*EIAA	32	5	0	0	0	0
EIB	20075	0	0	0	0	0
*EIBA	20075	0	0	0	0	0
EJ	661001	158256	0	0	0	0
EJA	661001	158256	0	0	0	0
*EJAA	661001	158256	0	0	0	0
EK	390415	73875	0	0	0	0
EKA	390415	73875	0	0	0	0
*EKAA	390415	73875	0	0	0	0
F	2299375	520520	663845	3483740	0	3483740
FA	873060	185223	0	1058283	0	1058283
FAI	525136	136282	0	661418	0	661418
*FAIA	525136	136282	0	661418	0	661418
FAL	347924	48941	0	396865	0	396865
*FALA	347924	48941	0	396865	0	396865
FB	603387	113610	9362	726359	0	726359
FBB	224486	59622	3745	287853	0	287853
*FBBA	224486	59622	3745	287853	0	287853
FBC	213555	19107	0	232662	0	232662
*FBCA	213555	19107	0	232662	0	232662
FBI	165346	34881	5617	205844	0	205844
*FBIA	165346	34881	5617	205844	0	205844
FC	400465	79024	654483	1133972	0	1133972

COMPUTATION SUMMARY

PREPARED: 94 OCT 04 1542 HRS
FACILITY NAME: NAVAL HOSPITAL OAK HARBOR
FACILITY CODE: 066097 DOD REGION: 11

QUARTER 4 : 01 JUL - 30 SEP FY 93 YEAR TO DATE
PAGE 05

ACCT CODE	DIRECT EXPENSE	SUPPORT COSTS	ANCIL COSTS	AFTER STPDN	NET PURIF	PURIFIED EXPENSE
FCA	94158	0	0	94158	0	94158
*FCAA	94158	0	0	94158	0	94158
FCC	94017	17785	578863	690665	0	690665
*FCCA	94017	17785	578863	690665	0	690665
FCD	212290	61239	75620	349149	0	349149
*FCDA	212290	61239	75620	349149	0	349149
FE	397109	138646	0	535755	0	535755
FEA	397109	138646	0	535755	0	535755
*FEAA	397109	138646	0	535755	0	535755
FI	716	205	0	921	0	921
FIA	716	205	0	921	0	921
*FIAA	716	205	0	921	0	921
FJ	24638	3812	0	28450	0	28450
FJA	24638	3812	0	28450	0	28450
*FJAG	24638	3812	0	28450	0	28450
*TOTAL	23306240	*****	*****	*****	0	23306240

APPENDIX G

PAGE: 02
COLLECTION PERIOD: 15 MONTHS
UNREPLICATED

CHAMPIUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
BASED ON CARE RECEIVED FROM OCT 1992 THRU SEP 1993
126 - NA BREFFERTON, MA

185-007 (OHR169)
DATE: 12 JAN 1994
TIME: 00:32:26
DE: 78, BENE ZIP

***** CATEGORY OF CARE - INTERNAL MEDICINE *****

ADVERSE REACTIONS ALLERGY DERMATOLOGY ENDOCRINOLOGY CASTRO-ENTEROLOGY HEMATOLOGY

INPATIENT HOSPITAL SERVICES

SER BENEFICIARIES 5 42 0 0 0 14 5
DEPT OF ACT DUTY SPONSOR 10 19 0 0 0 7 3
RETIREE 13 50 0 0 0 1 0
DEPT OF RET OR DEC SPONSOR 13 50 0 0 0 1 0
OITAL HOSPITAL ADMISSIONS 324 324 0 0 0 15 2
OSPITAL DAYS 6 0 0 0 0 0 0
VERAGE LENGTH OF STAY (DAYS) 3.09 3.09 0 0 0 0 0
TOTAL GOVERNMENT COST 454,803 454,803 0 0 0 126,809 0
OITAL PATIENT COST 51,591 51,591 0 0 0 5,509 0
OITAL GOVT AND PATIENT COST 1,140 1,140 0 0 0 13,318 0
OITAL GOVT COST PER ADMISSION 4,417.57 4,417.57 0 0 0 21,134.83 0
VG GOVT COST PER DAY 835.76 835.76 0 0 0 1,174.16 0

INPATIENT PROFESSIONAL SERVICES

SER BENEFICIARIES 3 92 0 0 0 27 7
DEPT OF ACT DUTY SPONSOR 3 37 0 0 0 4 0
RETIREE 3 37 0 0 0 4 0
DEPT OF RET OR DEC SPONSOR 22 633 0 0 0 132 3
NUMBER OF VISITS 235 235 0 0 0 132 3
TOTAL GOVERNMENT COST 1,234 1,234 0 0 0 29,892 8,485
OITAL PATIENT COST 1,234 1,234 0 0 0 29,892 8,485
TOTAL GOVT AND PATIENT COST 2,468 2,468 0 0 0 59,784 10,810
AVG GOVT COST PER DAY 3,468 3,468 0 0 0 59,784 10,810

II TOTAL INPATIENT SERVICES

USER BENEFICIARIES 17 98 0 0 0 50 2
DEPT OF ACT DUTY SPONSOR 34 98 0 0 0 30 6
RETIREE 17 98 0 0 0 16 3
DEPT OF RET OR DEC SPONSOR 34 98 0 0 0 16 3
TOTAL GOVERNMENT COST 587,531 587,531 0 0 0 104,944 135,294
OITAL PATIENT COST 140,228 140,228 0 0 0 18,732 7,834
TOTAL GOVT AND PATIENT COST 727,759 727,759 0 0 0 123,676 143,128
AVG GOVT COST PER ADMISSION 1,745.40 1,745.40 0 0 0 6,396.27 2,549.00
AVG GOVT COST PER DAY 4,937.32 4,937.32 0 0 0 1,249.33 1,252.72

V OUTPATIENT PROFESSIONAL SERVICES

USER BENEFICIARIES 165 477 0 0 0 571 100
DEPT OF ACT DUTY SPONSOR 113 477 0 0 0 571 100
RETIREE 113 477 0 0 0 571 100
DEPT OF RET OR DEC SPONSOR 113 477 0 0 0 571 100
NUMBER OF VISITS 130 130 0 0 0 202 41
TOTAL GOVERNMENT COST 3,159 3,159 0 0 0 705 472
OITAL PATIENT COST 1,114 1,114 0 0 0 3,049 65,837
TOTAL GOVT AND PATIENT COST 4,273 4,273 0 0 0 89,432 24,868
AVG GOVT COST PER VISIT 32.72 32.72 0 0 0 87,613 70,346
AVG GOVT COST PER DAY 242.67 242.67 0 0 0 172,045 137,445

OUTPATIENT CARE COST SHARED AS INPATIENT

USER BENEFICIARIES 0 0 0 0 0 0 0
DEPT OF ACT DUTY SPONSOR 0 0 0 0 0 0 0
RETIREE 0 0 0 0 0 0 0
DEPT OF RET OR DEC SPONSOR 0 0 0 0 0 0 0
TOTAL GOVERNMENT COST 0 0 0 0 0 0 0
OITAL PATIENT COST 0 0 0 0 0 0 0
TOTAL GOVT AND PATIENT COST 0 0 0 0 0 0 0

VI TOTAL INPATIENT AND OUTPATIENT CARE

USER BENEFICIARIES 173 511 0 0 0 528 103
DEPT OF ACT DUTY SPONSOR 116 511 0 0 0 528 103
RETIREE 116 511 0 0 0 528 103
DEPT OF RET OR DEC SPONSOR 116 511 0 0 0 528 103
TOTAL GOVERNMENT COST 67,927 67,927 0 0 0 194,346 201,132
OITAL PATIENT COST 16,580 16,580 0 0 0 106,346 32,494
TOTAL GOVT AND PATIENT COST 84,507 84,507 0 0 0 300,692 233,626
TOTAL PATIENT COST 114,710 114,710 0 0 0 300,692 233,626
TOTAL GOVT COST 69,797 69,797 0 0 0 300,692 233,626

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

IR085-007 (OHRL669)
RUN DATE: 12 JAN 1994
RUN TIME: 00:32:26
JOB: 78,BENE ZIP

CHAMPUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
BASED ON CARE RECEIVED FROM OCT 1992 THRU SEP 1993
126 - NH BREHERTON, WA

PAGE: 03
COLLECTION PERIOD: 15 MONTHS
UNDUPLICATED

INPATIENT HOSPITAL SERVICES										OUTPATIENT PROFESSIONAL SERVICES									
INPATIENT HOSPITAL SERVICES										OUTPATIENT PROFESSIONAL SERVICES									
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CHAMPAUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
 BASED ON CARE RECEIVED FROM OCT 1992 THRU SEP 1993
 126 - NA BREKERTON, WA

PAGE: 04
 COLLECTION PERIOD: 15 MONTHS

UNDUPLICATED

***** CATEGORY OF CARE *****

	DENTAL	OBSTETRICS	GYNECOLOGY	OPHTHALMOLOGY	PSYCHIATRY GROUP 1	PSYCHIATRY GROUP 2	SPECIAL PEDIATRICS
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	2	303	17	1	59	33	11
DEPT OF ACT DUTY SPONSOR	0	290	10	0	42	20	11
RETIREE	0	0	0	0	16	11	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL HOSPITAL ADMISSIONS	2	322	17	1	108	112	12
HOSPITAL DAYS	1.50	2.00	0.22	0.00	34.10	3.04	1.35
AVERAGE LENGTH OF STAY (DAYS)	0.00	1.80	0.11	0.00	5.32	0.35	0.35
TOTAL GOVERNMENT COST	11,622	552,570	48,301	3,408	646,902	429,683	109,916
TOTAL PATIENT COST	0	572,232	10,301	3,408	701,082	465,608	108,036
TOTAL GOVT AND PATIENT COST	12,320	1,124,802	58,602	6,816	1,347,984	895,291	217,952
AVG GOVT COST PER ADMISSION	5,985.50	1,777.10	2,818.35	4,100.00	9,532.34	13,271.44	9,719.64
AVG GOVT COST PER DAY	3,921.67	832.18	818.38	431.00	332.34	13,271.44	828.81
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	2	646	47	6	53	27	69
DEPT OF ACT DUTY SPONSOR	0	622	24	5	42	0	1
RETIREE	0	0	0	0	0	0	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL HOSPITAL ADMISSIONS	2	646	47	6	53	27	69
NUMBER OF VISITS	0	27	37	1	61	8	49
NUMBER OF NON-VISIT SERVICES	0	7,684	95	6	0	227	96
TOTAL GOVERNMENT COST	9,929	867,032	33,718	2,527	48,921	20,824	54,067
TOTAL PATIENT COST	0	80,202	33,718	2,527	48,921	20,824	54,067
TOTAL GOVT AND PATIENT COST	10,996	947,234	57,157	4,181	52,630	21,926	55,578
III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	3	650	49	7	67	43	74
DEPT OF ACT DUTY SPONSOR	0	626	25	5	49	29	70
RETIREE	0	0	0	0	0	0	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL HOSPITAL ADMISSIONS	3	650	49	7	67	43	74
NUMBER OF VISITS	0	24	24	2	19	12	6
NUMBER OF NON-VISIT SERVICES	0	1,419,601	83,039	3,027	695,826	445,310	160,984
TOTAL GOVERNMENT COST	16,622	1,513,465	115,679	3,027	764,790	487,535	163,614
TOTAL PATIENT COST	23,315	4,408,705	115,679	3,027	764,790	487,535	163,614
TOTAL GOVT AND PATIENT COST	8,347	5,922,170	231,358	6,054	1,529,580	975,070	327,228
AVG GOVT COST PER ADMISSION	2,749.00	2,137.95	4,690.70	3,027.00	10,238.74	13,915.94	14,634.91
AVG GOVT COST PER DAY	5,564.33	2,137.95	1,390.49	3,027.00	358.12	401.90	1,247.94
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	34	23	439	317	757	1,071	172
DEPT OF ACT DUTY SPONSOR	31	20	439	317	757	1,071	172
RETIREE	0	0	0	0	0	0	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL HOSPITAL ADMISSIONS	34	23	439	317	757	1,071	172
NUMBER OF VISITS	102	28	201	84	214	240	43
NUMBER OF NON-VISIT SERVICES	214	86	4,323	571	7,004	11,529	202
TOTAL GOVERNMENT COST	12,878	7,218	4,323	571	415,424	676,619	1,150
TOTAL PATIENT COST	4,276	3,285	4,323	571	415,424	676,619	1,150
TOTAL GOVT AND PATIENT COST	17,154	10,503	8,646	1,142	830,848	1,353,238	2,300
AVG GOVT COST PER VISIT	247.65	257.79	175.67	158.82	59.31	58.70	98.87
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	2	0	0	0	0	0
DEPT OF ACT DUTY SPONSOR	0	0	0	0	0	0	0
RETIREE	0	0	0	0	0	0	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	0	0	0	0	0
TOTAL PATIENT COST	0	0	0	0	0	0	0
TOTAL GOVT AND PATIENT COST	0	0	0	0	0	0	0
VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	35	658	660	17	778	1,092	234
DEPT OF ACT DUTY SPONSOR	22	634	452	16	759	1,071	172
RETIREE	0	0	0	0	0	0	0
DEPT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL HOSPITAL ADMISSIONS	35	658	660	17	778	1,092	234
NUMBER OF VISITS	10	24	211	85	220	248	49
NUMBER OF NON-VISIT SERVICES	29,571	1,427,159	247,518	84,682	1,111,250	1,121,929	180,955
TOTAL GOVERNMENT COST	11,078	1,523,368	247,518	84,682	1,111,250	1,121,929	180,955
TOTAL PATIENT COST	40,098	4,408,705	247,518	84,682	1,111,250	1,121,929	180,955
TOTAL GOVT AND PATIENT COST	51,176	5,932,073	495,036	169,364	2,222,500	2,243,858	361,910

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

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 RUN TIME: 00:32:26
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CHAMPUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
BASED ON CARE RECEIVED FROM OCT 1992 THRU SEP 1993
126 -- NH BREMERTON, WA

PAGE: 05
COLLECTION PERIOD: 15 MONTHS

PAGE: 05
D: 15 MONTHS
UNDUPLICATED

GRAND TOTAL
FOR ALL
CATEGORIES

**GRAND TOTAL
FOR ALL
CATEGORIES**

I INPATIENT HOSPITAL SERVICES

USER BENEFICIARIES	
DEPT OF ACT DUTY SPONSOR	
RETIREE	
DEPT OF RET OR DEC SPONSOR	
HOSPITAL ADMISSIONS	
TOTAL HOSPITAL DAYS	
AVERAGE LENGTH OF STAY (DAYS)	
AVERAGE DAILY PATIENT LOAD	
TOTAL GOVERNMENT COST	
TOTAL PATIENT COST	
TOTAL GOVT AND PATIENT COST	
AVG GOVT COST PER DAY	
AVG GOVT COST PER ADMISION	

II INPATIENT PROFESSIONAL SERVICES

USER	BENEFICIARIES	NO. OF ACT DUTY SPONSOR	RETIREE	DEPT OF RET OR DEC SPONSOR	NUMBER OF VISITS	NO. OF NON-VISIT SERVICES	TOTAL GOVERNMENT COST	TOTAL PRIVATE AND PATIENT COST
13	102	22	22	102	22	22	102	22
14	102	22	22	102	22	22	102	22
15	102	22	22	102	22	22	102	22
16	102	22	22	102	22	22	102	22
17	102	22	22	102	22	22	102	22
18	102	22	22	102	22	22	102	22
19	102	22	22	102	22	22	102	22
20	102	22	22	102	22	22	102	22
21	102	22	22	102	22	22	102	22
22	102	22	22	102	22	22	102	22
23	102	22	22	102	22	22	102	22
24	102	22	22	102	22	22	102	22
25	102	22	22	102	22	22	102	22
26	102	22	22	102	22	22	102	22
27	102	22	22	102	22	22	102	22
28	102	22	22	102	22	22	102	22
29	102	22	22	102	22	22	102	22
30	102	22	22	102	22	22	102	22
31	102	22	22	102	22	22	102	22
32	102	22	22	102	22	22	102	22
33	102	22	22	102	22	22	102	22
34	102	22	22	102	22	22	102	22
35	102	22	22	102	22	22	102	22
36	102	22	22	102	22	22	102	22
37	102	22	22	102	22	22	102	22
38	102	22	22	102	22	22	102	22
39	102	22	22	102	22	22	102	22
40	102	22	22	102	22	22	102	22
41	102	22	22	102	22	22	102	22
42	102	22	22	102	22	22	102	22
43	102	22	22	102	22	22	102	22
44	102	22	22	102	22	22	102	22
45	102	22	22	102	22	22	102	22
46	102	22	22	102	22	22	102	22
47	102	22	22	102	22	22	102	22
48	102	22	22	102	22	22	102	22
49	102	22	22	102	22	22	102	22
50	102	22	22	102	22	22	102	22
51	102	22	22	102	22	22	102	22
52	102	22	22	102	22	22	102	22
53	102	22	22	102	22	22	102	22
54	102	22	22	102	22	22	102	22
55	102	22	22	102	22	22	102	22
56	102	22	22	102	22	22	102	22
57	102	22	22	102	22	22	102	22
58	102	22	22	102	22	22	102	22
59	102	22	22	102	22	22	102	22
60	102	22	22	102	22	22	102	22
61	102	22	22					

III TOTAL INPATIENT SERVICES

[illegible]

IV OUTPATIENT PROFESSIONAL SERVICES

[illegible]

V OUTPATIENT CARE COST SHARED AS INPATIENT

[illegible]

VI TOTAL INPATIENT AND OUTPATIENT CARE

[illegible]

TOTAL GOVT AND PATIENT COST 345,394 924,069 188,815 836,451 93,768 309,708
NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

APPENDIX H

SUMMARY OF COSTS/WORKLOAD

	Total Exp	OBD's	Cost Per OBD	Total Admiss.	Cost Per Admiss.	ALOS
MEPRS	650000	475	1368	199	3270	2.38
CHAMPUS	168704	109	1546	31	5442	3.52

APPENDIX I

INPATIENT SPECIALTY NAVAL HOSPITAL OAK HARBOR, FY 1993

UCA CODE	DESCRIPTION
AAAA	INTERNAL MEDICINE
ABAA	GENERAL SURGERY
ACAA	GYNECOLOGY
ACBA	OBSTETRICS
ADAA	PEDIATRICS
ADBA	NURSERY
AEAA	ORTHOPEDICS
AGAA	FAMILY PRACTICE INTERNAL MEDICINE
AGCA	FAMILY PRACTICE OBSTERTICS
AGDA	FAMILY PRACTICE PEDIATRICS
AGEA	FAMILY PRACTICE GYNECOLOGY
AGHA	FAMILY PRACTICE NURSERY

APPENDIX J (GLOSSARY)

1. MTF - Military Treatment Facility
(same as Military Hospital)
2. DOD - Department of Defense
3. ALOS - average Length of Stay
4. FY - Fiscal Year
5. OBD - Occupied Bed Day
6. NAS - Non Availability Statement
7. CHAMPUS - Civilian Health and Medical Program of the
Uniformed Services
8. DEERS - Defense Eligibility and Enrollment Reporting
System
9. MEPRS - Medical Expense and Performance Reporting System

APPENDIX K (MAY'S METHODOLOGY)

Cost per admission = $w_i * C_i + \dots + w_n * C_n$ $i=1$ to n ,
where

w_i = number of OBD spent in work center i
 C_i = cost per OBD in work center i
 n = number of work centers.

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